

*Capacity-based mental health legislation and its impact on clinical practice:
1) admission to hospital.*

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INTRODUCTION

In “On Liberty”, John Stuart Mill wrote

“...the only purpose for which power can be exercised over any member of a civilised community against his will is to prevent harm to others...” J.S. Mill (1859)¹

Mill’s philosophy underlies the established principle within many democratic jurisdictions that medical treatment without consent, which may or may not include admission to hospital, of an adult is a battery actionable within the criminal and civil law². Whilst it has been argued that any treatment without consent is incompatible with liberal principles³, an approach that always respects a refusal of treatment can also be criticized. In this context the evocative expression “dying

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1 Mill, J. S. (1859) *On Liberty* (2 edn): Parker.

2 *Schloendorff v Society of New York Hospital* 211 New York Reports 125 (1914); *Re T (Adult: refusal of treatment)* [1992] 4 All England Law Reports 649

3 Szasz, T. (1999) Medical incapacity, legal incompetence and psychiatry. *Psychiatric Bulletin*, 23, 517–519; Gunn, M. (2000) Reform of the Mental Health Act 1983: the relevance of capacity to make decisions. *Journal of Mental Health Law*, 3, 39–43.

with their rights on” has been used to describe the plight of adults with mental illness allowed to exercise their autonomy and refuse treatment with serious adverse consequences⁴. In England and Wales it is the rulings from case law, and in the case of hospital-based treatment for a mental disorder, the 1983 *Mental Health Act*, which together provide the framework for resolving such potential dilemmas.

In a UK Government sponsored review of mental health legislation in England and Wales, an Expert Committee chaired by Professor Genevra Richardson recommended that any new legislation should be based on specific ethical principles. These included the principle of non-discrimination whereby the principles stated in case law that determine the basis for treatment of a physical disorder also applied in the case of mental disorder⁵. This principle is that it is for a capable person to decide for him/herself whether to agree to hospital admission or treatment and in the case of a person who was incapacitated, admission and treatment could take place if it was in his/her best interests. If a person had the capacity to consent, then neither admission or treatment without consent could take place except in circumstances in which the nature of the person’s mental disorder was such that others were at risk. However, the UK Government has rejected this approach to mental health legislation for England and Wales, although a compromise is proposed for Scotland⁶.

The ethical arguments for and against capacity based mental health law have been discussed in detail elsewhere⁷. However, empirical data relating to the feasibility and consequences of such change in the law are not currently available. This absence of data may have been one factor in the UK Government deciding not to adopt the Richardson Committee’s proposals, though, at the time of writing the exact form of any proposed Mental Health Act was still not certain. Significant factors appear to have been the political emphasis being placed on public protection rather than the right to, and need for, treatment. There may have been concern that such legislation would have been ‘too lenient’, and not enabled those people who might harm others to be detained.

In this study, as capacity is ‘decision-specific’, we have assessed the capacity of men and women to make decisions about admission and treatment separately, using the Law Commission’s definition of incapacity⁸. In this paper, we focus on a person’s capacity to consent to admission. Surprisingly, the courts in England and Wales have not directly explored the nature of the information relevant to a decision about admission to hospital. Admission without consent constitutes false imprisonment, which is both a civil tort, and a crime⁹. Whilst the lawful admission of those who do not consent has been one area of concern, the recent ‘Bournewood’

4 Treffert, D. (1973) Dying with their rights on (letter). *American Journal of Psychiatry*, 130 (1041).

5 Report of the Expert Committee (1999) Review of the Mental Health Act 1983. London: Department of Health. Paragraph 2.15

6 Reforming the Mental Health Act. Part 1 The New Legal framework, Department of Health, 2000; Adults with Incapacity (Scotland) Act, 2000.

7 Authors arguing for such legislative change include Zigmond, A. & Holland, A. J. (2000) Unethical mental health law; history repeats itself. *Journal of Mental Health Law*, 3, 49–56 and Szumukler, G. &

Holloway, F. (1998) Mental health legislation is now a harmful anachronism. *Psychiatric Bulletin*, 22, 662–665. Authors arguing against include Robinson, R. (2000) Capacity as the gateway: an alternative view. *Journal of Mental Health Law*, 3, 44–48 and Szasz, T. (1999) Medical incapacity, legal incompetence and psychiatry. *Psychiatric Bulletin*, 23, 517–519.

8 The Law Commission (1995) *Mental Incapacity (Law Commission No 231)*. London: The Stationery Office.

9 For recent authorities see *Collins v Wilcock* [1984] 3 All England Law Reports 374 and *R v Rahman* (1985) 81 Criminal Appeal Reports 349

case involving Mr L highlighted a different concern¹⁰. This was the absence of a legal framework safeguarding the rights of those apparently assenting to admission but, owing to the nature of their mental disability, not having the capacity to make that decision for him/herself. When Mr L's case was considered by the Court, his incapacity was taken as given, and what he needed to understand in order to give consent was not explored. The Appellate Committee of the House of Lords subsequently overturned the initial judgement that patients in L's situation ought to be formally detained using mental health legislation so that their statutory rights can be protected. Nevertheless, one of the members, Lord Steyn, thought that there was an argument that persons such as L should be detained if they required treatment of a mental disorder. As he pointed out: "Given that [compliant incapacitated] patients are diagnostically indistinguishable from compulsory patients, there is no reason to withhold the specific and effective protections of *The Mental Health Act 1983* from a large class of vulnerable mentally incapacitated individuals...The only comfort is that counsel for the Secretary of State has assured the House that reform of the law is under active consideration" (p. 306, *R v Bournewood* op.cit.).

Though there have been many discussions of the difficulties raised by the 'Bournewood' case¹¹, a solution has yet to be found. Recently, the Government suggested that the safeguards currently offered by the Mental Health Act Commission to men and women who are detained should be extended to those like Mr L¹². However, no legal source in England and Wales has examined what is meant by capacity to consent to admission despite the estimate that a further 22,000 detentions a year might occur if compliant patients had to be admitted formally¹³. The MHA does not demand a consideration of this issue at any point, and it is therefore not specifically addressed in the Mental Health Act Manual¹⁴.

In contrast, in the U.S.A., the Courts have considered the issues relating to consent to admission. In one important case, *Zinerman v Burch*¹⁵, the Supreme Court ruled that voluntary admission entails more than simply the willingness to be admitted, but no guidance was given as to the information and abilities involved in meaningful consent. In the absence of such guidance, others have considered this issue. Hoge (1994), for example, proposed a 'weak' and a 'strong' model¹⁶. The 'strong' model entails understanding of all the ramifications of admission to a psychiatric facility, including eventualities such as stigma on discharge. However, he rejected this on the grounds that it demands more understanding than is required for other decisions. Instead, consistent with the principle established in English case law¹⁷, he favoured the 'weak' model. In this model, an understanding of information provided in 'broad terms and simple language' is sufficient.

10 *R v Bournewood Community and Mental Health NHS Trust, ex parte L* [1998] 3 All England Law Reports 289.

11 Dickenson, D. (2001) Decision-making competence in adults: a philosopher's viewpoint. *Advances in Psychiatric Treatment* 7, 381–388; Dickenson, D. & Shah, A. (1999) *Bournewood: an indefensible gap in mental health law: Law Commission's proposals for incapacity jurisdiction strike reasonable balance* (letter) *British Medical Journal* 318, 126–127.

12 *Reforming The Mental Health Act*, Department of Health, 2000, see Chapter 7.

13 Eastman, N. & Peay, J. (1998). *Bournewood: an indefensible gap in mental health law*. *British Medical Journal* 317, 94–95.

14 Jones, R. (2003). *Mental Health Act Manual*. Eighth Edition. Sweet and Maxwell: London,

15 *Zinerman v Burch*, 494 United States Reports 113

16 Hoge, S.K. (1994). On being "too crazy" to sign into a mental hospital: The issue of consent to psychiatric hospitalisation. *Bulletin of the American Academy of Law and Psychiatry* 22, 431–455.

17 *Chatterton v Gerson* [1981] *Queen's Bench* 432.

A similar position was reached by a task force of the American Psychiatric Association¹⁸ and has been proposed by the Law Commission of England and Wales (see 7 above).

Many of the early studies of consent to admission to hospital judged participants against a standard based on the 'strong' model. For example, Olin and Olin¹⁹ interviewed one hundred consecutive in-patients in a single State of the U.S.A. All the participants were in hospital voluntarily, and had signed their State's pre-admission contract for voluntary admissions. *Inter alia*, this contract stated that they needed to give three days' notice of an intention to leave hospital, and that a single doctor might then say that they were not allowed to leave. This was understood by only eight (8%) of the patients. Similar findings were also reported in another American study²⁰, in which the understanding of legally and clinically significant information by fifty voluntary in-patients admitted 24–48 hours earlier was assessed. Less than a third of the participants appeared to have a satisfactory legal or clinical understanding of the admission process.

Following the APA's report, research based on the 'weak' model was carried out. Poythress *et al*²¹ compared the understanding of voluntary and involuntary in-patients of a very simple disclosure. This contained four facts about admission to hospital. Sixty-five of one hundred and twenty participants (54%) were unable to understand and retain the information. However, the study population may have been unusual in that, regardless of their subsequent status, all the participants had initially been admitted for assessment against their will. This suggests that they may all have had severe mental health problems. In a study of 100 voluntarily admitted patients each was assessed using an even lower standard of understanding²². The participants were asked to demonstrate they understood that they had been admitted to a psychiatric facility for treatment and that, if they requested release, it might be delayed. The relevant information was given to the participants before testing and their understanding of the disclosures assessed by both asking them to recall the information given and then to recognise as 'true' or 'false' further statements relating to the purpose of admission and discharge arrangements. Following the disclosure, 53 of the 100 participants were able to recall fully both elements of understanding and 82 of the participants were able to identify correctly as 'true' or 'false' the relevant information when presented to them.

At first sight, decisions relating to admission to hospital may seem relatively trivial compared with, for example, decisions about receiving medication. After all, for voluntary patients, admission involves making a decision, which can be reversed almost immediately, about entering a building and staying for a period of time. However, a more detailed examination indicates that admission to hospital has significant consequences. First, in a ward environment, the freedom to make choices (e.g., about when to eat meals or whether to drink alcohol) is inevitably restricted, and there is a loss of privacy. In addition, there is a risk of physical or sexual assault²³. Secondly, when it comes

18 American Psychiatric Association (1993). *Consent to voluntary hospitalization. Task Force Report No 34.* American Psychiatric Association: Washington DC.

19 Olin, G. B. & Olin, H. S. (1975). *Informed consent in voluntary mental hospital admissions.* American Journal of Psychiatry 132, 938–941.

20 Appelbaum, P. S., Mirkin, S. A. & Bateman, A. (1981). *Empirical assessment of competency to consent to psychiatric hospitalisation.* American Journal of Psychiatry 138, 1170–1176.

21 Poythress, N., Cascardi, M. & Ritterbrand, L. (1996). *Capacity to consent to voluntary hospitalisation:*

searching for a satisfactory Zinerman screen. Bulletin of the American Academy of Psychiatry and the Law 24, 439–452.

22 Appelbaum, B.C. Appelbaum, P. S. & Grisso, T. (1998). *Competence to consent to voluntary psychiatric hospitalisation : A test of a standard proposed by APA.* Psychiatric Services 49, 1193–1196.

23 Crowner, M., Stepic, F., Peric, G. & Czobor, P. (1994) *Typology of patient-patient assaults detected by video-cameras.* American Journal of Psychiatry 151, 1669–1672 and Nilbert, D., Cooper, S. & Crossmaker, M. (1989) *Assaults against residents of a psychiatric institution.* Journal of Interpersonal Violence 4, 342–349.

to psychiatric admission, an individual's decision not to remain on the ward cannot always be exercised. Under the current legislation in England and Wales, patients who have been admitted informally can later be detained on the opinion of one, often junior, psychiatrist. In addition, in contrast with hospitalisation for a physical disorder, decisions about psychiatric admission are rarely based simply on diagnosis. More often, in psychiatric practice, a decision to admit reflects concern about the probable degree of risk the person may pose to him/herself or others. Thus, the capacity to make such a decision can only be evaluated in the context of a person's understanding of the potential risks associated with their psychiatric disorder, including self-harm, suicide, and interpersonal violence. The decision-making in relation to admission to hospital is therefore, arguably, as complex and significant as that involved in accepting medical treatment. In addition, coercion can be experienced whether admission is by a compulsory legal process or "voluntary"²⁴.

The aims of this part of the study were, therefore, to determine the extent to which informal and formal patients were capable of consenting to admission. We hypothesised

- a) That the presence of psychotic illness and/or a learning disability would be the best clinical predictors of incapacity.
- b) That a significantly greater proportion of those presently detained under the MHA would lack the capacity to consent to admission compared to those who were informal.
- c) A proportion of those admitted informally would be found to be lacking in the capacity to consent to their admission.

METHODS

Ethical permission was obtained for the whole study from the Local Research Ethics Committee. The study aimed to be as naturalistic as possible, mimicking the procedure that would have to be followed if capacity-based mental health legislation was in place. The criteria used for capacity were firmly based on case law and on the guidance listed above. We took the view that, as occurs with the current MHA (for example, judging nature or degree of mental disorder), the determination of capacity required a judgement on the part of the clinician.

Participants

A consecutive series of patients between the ages of 16–65 years newly admitted to hospital in the local mental health and learning disability services were asked to participate in the study within 48 hours of admission (excluding those with eating disorders or primarily substance misuse²⁵). Information was obtained from case notes regarding legal status, psychiatric diagnosis (ICD-10 criteria), and medication. Following the first interview, participants were asked if they would be re-interviewed one week after admission.

24 Hoge, S.K., Lidz, C., Mulvey, E., Roth, L., Bennet, N., Siminoff, L., Arnold, R. & Monahan, J. (1993) Patient, family, and staff perceptions of coercion in mental hospital admission: an exploratory study. *Behavioural Science and the Law* 11, 281–293.

25 The former owing to their inclusion in another study which was to occur locally of capacity to consent in eating disorders and the latter owing to their specific exclusion from the 1983 MHA.

Assessment of capacity to make a decision about admission to hospital

Relevant information

Since there is no clear legal precedent in England and Wales, a mental health lawyer (MG) identified the information relevant to decision-making about hospital admission from case law relating to treatment decisions, and from the existing literature. Law relating to treatment decisions seemed most closely analogous and admission can be considered as the provision of nursing care in a specific place. Initially, five elements were identified. However, following a pilot study, the list was amended as it became clear that discussion of the 'purpose of admission' could only occur once the nature of and behavioural consequences of the illness had been explicitly discussed. The final seven elements comprised: (i) perception of illness requiring admission (ii) perception of the behavioural consequences of illness (iii) the nature of admission – practical (iv) the nature of admission – legal (v) the purpose of admission (vi) risks of admission and (vii) risks of non-admission.

Establishing criteria for assessing responses

A scheme for assessing participants' responses was devised, based on existing case law related to capacity to consent to treatment and the work of the Law Commission and modified so that it was applicable to decisions about admission. The thresholds were reviewed by one of the authors, a mental health lawyer (MG). These are set out element by element in Figure 1.

Improving capacity

An information sheet written in 'broad terms and simple language' and meeting all the legal requirements for relevant information relating to a decision about admission was prepared, and given to each person after the initial stage of capacity assessment.

Statistical analysis

The Statistical Package for the Social Sciences Version 9.0 (SPSS–Inc, 1999) was used for data analysis. The association between dichotomous variables was examined by calculation of odds ratios and their 95% confidence intervals, presented below as (Odds Ratio..... 95% CI.....). Correlation between dichotomous variables was examined by calculation of the Kappa correlation coefficient. The binomial distribution was used to compare proportions. In all tests significance was assumed where the p value was equal to, or less than, 0.05.

RESULTS

Participant characteristics

Sixty-seven patients newly admitted to inpatient services because of psychiatric problems were approached and asked to participate. Forty-nine individuals (73%) agreed to take part and all completed the assessment of capacity to consent to admission. The sample comprised 28 men and 21 women with a median age of 36 years of whom 43 were recruited from general psychiatric services and six from inpatient services for people with a learning disability. Of these, twenty-two

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| Element | Understanding required |
|---|---|
| Perception of illness requiring admission | That there was a problem internal to the participant not simply due to external factors or physical illness even if these had played a role in causation. |
| Perception of behavioural consequences of illness | That there was a risk of serious adverse consequences for the participant's health, safety, social network or other people of the disorder above. |
| Nature of admission – Practical | That admission was different to being at home with respect to the freedom to do as the individual chooses and it involves sharing a space and living with others. |
| Nature of admission – Legal | Informal participants – Understanding that admission was voluntary. Detained participants – Understanding that the admission was involuntary due to a legal process and therefore was different from the normal circumstances. |
| Purpose of admission | The potential of admission to alleviate the illness or to reduce the risk of the behavioural consequences of the illness. |
| Risks of admission | That admission constrains the participant's freedom and involves sharing a space with others. |
| Risks of non-admission | To understand the risk of occurrence of the behavioural consequences of the illness. |

Figure 1 – Level of understanding of each element required for participant's response to be judged 'satisfactory'

had the following psychotic illnesses: schizophrenia (10), drug induced psychosis (1), unclassified psychosis (5), mania (2), psychotic depression (2), prominent hallucinations in the context of alcohol withdrawal (2).

Ten (20%) people were admitted using the provisions of the *Mental Health Act 1983*. This figure is comparable to the proportion normally admitted compulsorily to the in-patient mental health or learning disability services in Cambridge Health District. The mean delay between admission and interview was forty-four hours. Examination of the case notes indicated that the participants did not differ significantly from those who did not take part with respect to age, gender and diagnosis.

Inter-rater agreement

The reliability of the judgements of capacity to consent to admission made by the interviewer (JB) was assessed using transcripts of the interviews with ten (20%) of the participants. An experienced psychiatrist (AJH) independently rated these transcripts.

Agreement with respect to understanding in individual elements

Kappa correlations were calculated separately for agreement between the raters for each element relevant to an admission decision. The level of agreement between the raters was statistically significant ($p < 0.05$) for six of the seven elements. For understanding of the risks of admission, there was a negative correlation due to the raters having different views about rating people who perceived no risks to admission.

Agreement with respect to overall capacity

The level of agreement about overall capacity was satisfactory ($k = 0.737$, $p = 0.16$). There was only one disagreement where raters disagreed over understanding of the purpose of admission and hence overall capacity.

Capacity to consent to admission

Overall, thirty-three (67%) of the participants were judged to have the capacity to consent to their admission.

The group judged to have capacity

On average, at least six of the possible seven elements were understood by this group (mean: 6.5; range: 3–7). Twenty of the 33 (60%) men and women responded satisfactorily in all seven elements. Thirteen of the 17 (76%) sub-categories which the capable participants were judged not to have answered satisfactorily related to understanding the nature of admission in practical and legal terms.

The group judged not to have capacity

Sixteen people were judged unable to consent to admission. Nevertheless, everyone could understand at least one element of information related to his or her admission. The average number of elements in which those judged to lack capacity overall demonstrated adequate performance was less than four (mean: 3.88; range: 1–5).

Relationship between overall judgements of capacity and adequacy of response to each element

Using logistic regression analysis, it was found that a judgement of incapacity was associated with an unsatisfactory response to the element 'perception of risks posed by illness' (χ^2 (1df) = 12.89, $p < 0.001$), and an unsatisfactory understanding of 'the purpose of admission' (χ^2 (1df) = 10.09, $p < 0.01$). Once these elements had been considered, no other significant relationships were found.

The use of these two elements alone predicted correctly the independent clinical judgements of 47 (95.9%) of the 49 participants. On its own, 'perception of risk' predicted 45 (91.8%), whilst 'understanding of purpose of admission' alone allowed the correct prediction of 41 (83.67%) judgements.

Association between capacity to consent to admission and legal status

Thirty-one of the 39 informal patients (79%; 95% CI: 66–92%), and two of the detained patients (20%; 95% CI: 0–44.9%) were judged to have capacity to consent to admission. A clinical judgement that the person had capacity was therefore significantly more likely when he or she had been admitted informally (Ratio of odds of capacity (informal/formal) = 15.5; 95% CI: 2.74–87.74).

Association between capacity to consent to admission and diagnosis

There was a significant relationship between having a psychotic illness and incapacity to consent to admission. Fourteen of the sixteen persons unable to consent had such a diagnosis (Ratio of odds of incapacity (psychotic/non-psychotic) = 21.73; 95% CI: 4.07–111.11). In contrast, all twelve participants with a diagnosis of non-psychotic depression were able to consent to admission.

Relationship between capacity to consent to admission and in-patient service

Although only two of the six receiving care in the in-patient service for people with mild learning disabilities were judged to have the capacity to consent to admission, there was no significant association between admission to this service and the ability to make this decision (Ratio of odds of incapacity (learning disability services/general adult services) = 5.15; 95% CI: 0.83–32.26). The lack of statistical significance reflects the relatively small number of admissions to this service over the time of the study.

Effect of information on understanding of admission decisions

The effect of the information sheet was categorised using a three-point scale: 'no effect', 'some effect' or a 'significant effect'. This last category referred to a change in a particular response from unsatisfactory to satisfactory. Whilst there were no participants for whom the overall judgment of capacity changed following the presentation of the information, Figure 2 shows that it had a considerable impact on several of the individual elements. It appears that the information is of most value where it relates to admission generally, for instance the legal aspects of admission, rather than a person's individual circumstances such as their personal risk of suicide or self-neglect.

Follow-up interviews

Eighteen (36%) of the participants were re-interviewed one week after their initial interview. Not surprisingly, perhaps, all the twelve patients who were judged at the first interview to have the capacity to consent to admission remained able to make this decision. There was a change in only one of the six patients without initial overall capacity; at follow up he was judged to have capacity as there was a marked improvement in his understanding of the purpose of admission.

| Element | No effect | Some effect | Significant effect |
|-------------------------------------|-----------|-------------|--------------------|
| Illness | 46 | 3 | 0 |
| Behavioural consequences of illness | 48 | 1 | 0 |
| Nature of admission – practical | 46 | 3 | 0 |
| Nature of admission – legal | 43 | 2 | 4 |
| Purpose of admission | 47 | 2 | 0 |
| Risks of admission | 47 | 2 | 0 |
| Risks of non-admission | 48 | 0 | 1 |

Figure 2 – Effect of information about admission decisions on the participants' (N=49) responses

Understanding of information about the admission

To identify which elements of the relevant information appeared most complex, we have reported the numbers whose performance was judged unsatisfactory in each element, giving examples of their responses to questions used to elicit information.

Perception of illness needing admission

The responses of seven participants were judged unsatisfactory on this element. All were diagnosed as having a psychotic illness, (Ratio of odds of unsatisfactory performance in this category (psychotic/non-psychotic) = 1.467; 95% CI: 1.10–1.95), and all were considered lacking capacity to consent to admission overall (Ratio of odds of incapacity (unsatisfactory performance in this element/satisfactory) = 1.77; 95% CI: 1.15–2.73). Three participants were judged unsatisfactory due to an external attribution of problems leading to admission, e.g., “My dad stole my crisps and then I went out...now I’m here”. Two responses were judged to be delusional e.g. “The man upstairs has been spraying white powder all over my flat...every time I turn my back....it’s made me right ill”. Two responses were considered unsatisfactory on the grounds of being unclassifiable, e.g. “It’s all to do with cognitive maps, Rubik’s cubes and space and time”.

Perception of behavioural consequences of the illness

Sixteen people (32%), including all seven who had performed unsatisfactorily on the previous element, did not consider that there was any risk associated with their disorder. An unsatisfactory rating on this element was associated with a high risk of overall incapacity (Ratio of odds of incapacity (unsatisfactory performance on this element/satisfactory) = 108.5; 95% CI: 13.84–856.5), with 14 of the 16 participants lacking capacity overall. Two participants, rated as unsatisfactory on this element, were judged to have overall capacity to consent. Neither was rated as unsatisfactory in any other element. Being a detained patient was highly associated with an

unsatisfactory response in this category (Ratio of odds of unsatisfactory performance in this element (detained/Non-detained) = 7.78; 95% CI: 1.67–36.43). Seven participants were judged unsatisfactory as risks were anticipated, but not linked to illness, e.g. [In response to a delusion] “I’ve just got to go out and kill that bastard, he’s ruined my life.” Four participants were unable to anticipate any consequences at all of their disorder, and two perceived trivial consequences of their disorder, e.g. a female admitted dehydrated with psychotic depression who described the risks as “I was having trouble talking to people.”. Two were unable to consistently appraise the risks e.g., “I get suicidal thoughts...I don’t pose a danger...I stopped eating....I was probably going to start again.” One participant, suffering from mania, was able to see the consequences but did not believe them.

Understanding of nature of admission (practical)

Ten people failed to give satisfactory responses when questioned about this element of decision-making about admission to hospital. Having no prior experience of psychiatric admission was not a risk factor for unsatisfactory performance on this element. Only two of the naïve participants demonstrated unsatisfactory performance (Ratio of odds of unsatisfactory performance (no previous experience/previous experience) = 0.64; 95% CI: 0.12–3.48). Nine participants were judged unsatisfactory with respect to this element due to provision of unsatisfactory or irrelevant information e.g. “They’ve got a toaster, you know”, or, as in one case, because the person asserted that there was no difference between hospital and his home.

Understanding of nature of admission (legal)

The performance of twelve participants was judged as unsatisfactory with respect to this element of understanding. Eleven of these were informal patients, all of whose responses were judged unsatisfactory due to their lack of appreciation of the possibility of leaving the hospital if they wished to. The detained patient who responded unsatisfactorily in this element was aware of the fact that he was not able to leave, but saw this simply as a perverse decision of the nurses caring for him.

Nine participants (2 detained; 7 informal) displayed a higher level of legal understanding, for instance detailed knowledge of the workings of the *Mental Health Act*. There was no association between this higher level of understanding and the number of previous admissions or detentions.

Understanding of the purpose of admission

Eight participants did not satisfactorily understand the purpose of admission, three of these being detained patients. All eight people unable to understand the purpose of their admission were in the group eventually found to lack capacity to consent to admission. This is a significant relationship (Ratio of odds of overall incapacity (unsatisfactory performance in this element/satisfactory) = 5.13; 95% CI: 2.75–9.54). The three people demonstrating an unsatisfactory perception of illness but able to understand the purpose of their admission perceived that they had gone to hospital for a therapeutic reason, to remove them from an externally perceived problem, or from a delusional problem.

Understanding of risks of admission

Only six participants were not able to describe the risks of admission satisfactorily. Five of the six participants judged as giving an unsatisfactory response on this element were found to lack capacity overall (Ratio of odds of overall incapacity (unsatisfactory performance on this element/satisfactory) = 14.55; 95% CI: 1.53–138.51). All six judged as performing unsatisfactorily were informal patients, this association being statistically significant (Ratio of odds of overall incapacity (informal/detained) = 1.30; 95% CI: 1.10–1.57).

The usual reason for being judged as giving an unsatisfactory response was the assertion that hospital was good or enjoyable. Clearly one's overall impression may well be that hospital is enjoyable, but there are always drawbacks, such as lack of control over meal times. It was felt important that people acknowledged, however minimally, these problems, even if they overall rated the experience as neutral or enjoyable. This was the major source of disagreement between the raters.

Understanding of risks of non-admission

Nine participants were judged as not satisfactorily understanding the risks of their non-admission to hospital. Eight of these were eventually judged to lack overall capacity, a significantly relationship (Ratio of odds of overall incapacity (unsatisfactory performance in this element/satisfactory) = 32.00; 95% CI: 3.48–294.20). Six of the nine lacking capacity for this element were detained. This was a significant excess (Ratio of odds of unsatisfactory performance in this element (detained/non-detained) = 18; 95% CI: 3.20–101.38). Seven were simply unable to perceive the consequences of their illness and thus not able to comment upon what might happen if they were not admitted, and two participants with diagnoses of depression simply made "don't know" replies. Though able to perceive their suicide risk, they answered "I just don't know" when questioned on possible events if they had not been admitted.

DISCUSSION

In this study a method for assessing the capacity of a person to consent to admission to hospital has been developed, and it has been shown that two raters can agree broadly on capacity judgements. The relationship of decision-making capacity to current legal criteria for detention has been investigated. Whilst English courts have not yet considered this matter, by extrapolating from legal sources dealing with capacity to consent to treatment, and taking fully into account the law relating to false imprisonment, it was possible to devise elements of relevant knowledge.

In the pilot study it was clear that a determination of the person's perception of his/her illness was a necessary first step in the assessment process. As with assessment of capacity to consent to treatment, this makes explicit that which has been implied in previous case law and it clearly represents information relevant to the decision in hand. Acknowledging that there is at least the possibility that one is 'ill' is a necessary pre-condition of recognising the need for admission and/or treatment. However, in the assessment of admission decisions, a further element of information was added, that of 'perception of risks posed by the illness'. The justification for this requires consideration of the purpose of hospital admission. In the case of psychiatric disorders, admission is not fundamentally to treat the illness in itself, but to prevent the potential adverse behavioural

consequences of a mental disorder during recovery, whether spontaneously or in response to treatment. Admission may have a therapeutic role of itself, for instance, by removing a person from a home situation that has perhaps precipitated an episode of illness. However, in the absence of potential risks, medication and other specific interventions are the effective treatment, not hospital admission. For example, a person suffering from depression can make a decision whether or not to have antidepressant treatment based on his/her understanding that he/she has depression. However, the understanding that one has depression does not, of itself, explain why in-patient treatment, as opposed to out-patient treatment, is necessary. This distinction is in terms of the potential suicide risk, damage to relationships and social networks, and/or the need for satisfactory nutrition and hydration whilst ill.

Seven participants did not satisfactorily perceive that they might be ill. All of these suffered from a psychotic illness and all were judged as unable to consent or withhold consent to admission. However, sixteen people in total lacked capacity and were unable to satisfactorily understand the risks posed by their illness. There were also nine people who understood that they were ill, but not the problems and risks that their disorder posed to them or others. Fourteen of the sixteen unable to understand the risks posed by their illness were found to lack capacity overall.

The decision to use this element of ‘risks posed by illness’, not explicit in previous case law, might be criticised on the grounds that it turns a capacity assessment into a risk assessment. This is not the case. The participant was judged on his/her understanding of the risks posed by his/her illness, not by the magnitude of the risks. The functional approach demands that people make decisions in full possession of the facts. It does not demand that these decisions always ensure a good outcome.

Two people in the study were detained on the grounds of risk, and actually understood the risks, one believing that the risks he posed to others were justified by their behaviour towards him and that, in any case, he would prefer to be arrested than sectioned as arrest is more “manly” and less patronising. The other could see the risks posed by his manic behaviour to his business credibility, but felt that the loss of his business was preferable to compulsory admission and treatment. It might be argued that though these participants were acting in possession of all the facts, they still made decisions they would not have made when well. The proposal (Report of the Expert Committee, 1999) that capacity might be extended to include judging people incapable when they make decisions they would not make when well was made by the Richardson Committee. It has great face validity and is certainly a tempting option when people apparently in possession of the facts still seem set to act unwisely. The difficulty is that it allows any decision made by a person with a mental illness to be overridden by the treating clinician by invoking this formulation of incapacity. It is impossible for the patient to refute it on objective grounds. We did not use it in this study as it would be possible to categorise any dissenting or unwise decision made by a mentally ill person as incapable, and although the doctor could not prove the link, neither could the patient disprove it, and the doctor’s opinion would trump that of a patient.

When the results of this part of the study are considered together with the ‘treatment’ study²⁶ there are a proportion of people unable to make decisions regarding admission, but able to consent to treatment. Thus, there is a group who could be detained compulsorily but not made to have

26 Bellhouse, J.E., Holland, A.J., Clare, I.C.H. et al *Capacity-based mental health legislation and its impact on clinical practice: 2) treatment*, *J. Mental Health Law* (2003) page 24.

treatment unless they were willing to consent. The reason this difference exists is that treatment decisions are conceptually much simpler than admission decisions. Admission decisions are more likely to represent a life and death decision, and as such, more stringency is needed in assessing capacity/incapacity.

The proposal that people with mental disorder ought to receive compulsory treatment only when they are unable to make the decision for themselves has a strong ethical appeal. On what other basis should an adult's decision be overridden? This principle is considered adequate for the physically ill. However neat the ethical arguments appear on paper, such a proposal should remain theoretical and not be implemented until the feasibility of the proposals and their consequences are known. A sound ethical basis is necessary, but not sufficient, for ethically sound law. Such an approach could not be considered truly ethical if many more suicides and homicides resulted, or it proved unworkable. In the treatment paper we discuss the feasibility of assessing capacity to treatment of people newly admitted. Taking admission and treatment together we are in a position to say something about the likely consequences of such legislative change. The main points are as follows:

1. Although there is considerable overlap, capacity-based mental health legislation, as described in the Introduction, would not result in exactly the same people being liable to be detained as under the current MHA.
2. A small proportion of people who are currently detainable may not be if this proposal were adopted. Two of ten detained people in the study were capable of consenting to admission. One of these would still be detainable if risk to others was considered sufficient grounds for overriding a competent adult. Whether competent adults who pose a risk to others should be dealt with using mental health law or criminal law is a debatable point²⁷.
3. Admission and treatment are currently considered together. If they were to be considered separately, as a functional approach to capacity demands, then the problem of a person who can be detained in hospital but not treated would need to be addressed. This is an issue in parts of the USA where admission occurs using risk based "commitment criteria" but involuntary treatment is a competency issue.
4. Psychotic illness is a significant risk factor for incapacity and as such the capacity of this group to make significant decisions should be considered closely.
5. There are a number of people in hospital informally who lack the capacity to consent to their admission, and fall into the "Bournewood gap". This needs consideration if assenting incapable people are to have their rights protected.

The Government's plans for a new MHA (at least those set out in the White Paper) do not include making capacity assessment part of the criteria for the use of compulsion. This represents a missed opportunity but the future will present other opportunities for this argument to be aired and for this to be rectified. Presented here are data that support the contention that, as well as a strong ethical argument in support of such change, there is also no reason to think that such change might be unworkable or have disastrous consequences. Furthermore, capacity can be assessed with a reasonable level of agreement, thus enabling consistent clinical practice. Future debate on the ethical and policy aspects of mental health law should, where possible, be informed by empirical study.

27 Szmukler, G. & Holloway, F. (1998). *Mental health legislation is now a harmful anachronism*. *Psychiatric Bulletin* 22, 662–665.

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